THE RELATIONSHIP BETWEEN THE PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS AND THE STATE HEALTH DEPARTMENT*

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As we meet today, the health care delivery system in this country, as all human services systems, awaits a Congressional "second opinion" on the Reagan administration's plan for major budget surgery. That second opinion will not only determine the individual futures of such initiatives as Professional Standards Review Organizations and Health Systems Agencies but will have a significant impact on the overall function of health care delivery.

To assess fully the potential impact the Reagan plan for elimination of Professional Standards Review Organizations would have on this state, it is essential briefly to outline the history of utilization review efforts in New York and to describe the current relationship between the Professional Standards Review Organizations and the Health Department.

Experience with the financing and delivery of hospital services in the early years of the Medicare and Medicaid programs gave rise to a widespread conviction that a more structured approach to reviewing and controlling the utilization of hospital services was needed. This conviction lead to creation of the New York State Hospital Utilization Review system which gave the State Health Department a new and powerful tool for analyzing utilization patterns among Medicaid patients and for

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following up on evidence of overutilization. At the national level a similar conviction led to enactment in 1972 of the Professional Standards Review Law, Public Law 92-603.

By 1976, however, neither of these initiatives seemed to have had much success in effectively controlling utilization of hospital services. The state itself, partly because of inability to control burgeoning Medicaid costs, faced the real possibility of bankruptcy. In response to that threat, the governor proposed and the legislature enacted a comprehensive program to control health care costs. As part of that program, Chapter 76 of the Laws of 1976 was adopted. That law specifically initiated a program for state personnel to review inpatient hospital claims on-site, at the hospital, prior to their submission for payment under Medicaid to determine the necessity of the services delivered, and their conformance to state utilization control standards. The law also set some of the standards against which the state's on-site reviewers should judge claims being submitted for Medicaid payment.

By the end of 1976 the on-site program was operating in most of the large hospitals in the state that cared for significant numbers of Medicaid patients. The state's new standards, combined with strict enforcement by on-site staff, had the intended effect of reducing Medicaid expenditures for inappropriate or unneccessary hospital services. However, the on-site program brought the state into direct conflict with fledging Professional Standards Review Organizations, which claimed that under the terms of Public Law 92-603 they had exclusive authority to make binding decisions concerning the appropriateness of medical services.

The fundamental legal issue at the heart of the conflict between the state and the Professional Standards Review Organizations was resolved in 1977 with the passage of Public Law 95-142. The amendments to the original Professional Standards Review Organization statute included in Sections 1154 and 1155 of this act made it clear that binding payment authority lay with the Professional Standards Review Organizations. However, the law also explicitly recognized the role of states as full partners with the Professional Standards Review Organizations in assuring the appropriateness of medical care delivered under the Medicaid program. Working within the framework of this legislation, the Office of Health Systems Management and the Professional Standards Review Organizations proceeded to develop a memorandum of understanding that

defined in detail a new, cooperative relationship between the Professional Standards Review Organizations and the state.

That memorandum of understanding utilizes those criteria and procedures to determine medical necessity which were part of the legislatively mandated utilization review process in this state. This process includes the following features. Weekend admissions—that is, stays beginning on Fridays or Saturdays when procedures are scheduled for Mondays, in those hospitals not prepared to render full services to patients admitted on those days are disallowed. Preoperative stays are limited to one day unless affirmative justification is presented to and accepted by the Professional Standards Review Organization. Expedited preadmission review for 11 elective surgical procedures identified by the National Professional Standards Review Council is required. Continued-stay reviews are required in all cases three days after admission. Second opinions are required for overutilized or high-risk procedures and for individual practitioners deemed by the Professional Standards Review Organizations not to be performing in accordance with acceptable medical practice. Listing simple surgical procedures to be performed only on an outpatient basis unless otherwise explicitly justified is required.

Acceptance of the memorandum of understanding by each of the Professional Standards Review Organizations and the Office of Health Systems Management and approval of it by the Department of Health and Human Services resulted in the termination of the state's on-site program, and established the basis for the initiation of two new programs. The first program was designed to protect the state's interest in controlling misutilization of Medicaid services by permitting state monitoring of Professional Standards Review Organization review performance. The second was to permit comparison of the effectiveness of a decentralized Professional Standards Review Organization review process and that of a centralized state agency review.

The Professional Standards Review Organization Monitoring Program, the first of the two, has been operational since March 1, 1979. Our experience with the program has been positive in reducing unnecessary utilization of acute care services. There are, of course, individual points of concern with the program; some Professional Standards Review Organizations have shown significant improvements while others have experienced little change in their effectiveness since the program began. Results of our monitoring efforts are shared with individual Professional

Standards Review Organizations on a regular basis so that differences in approach or mechanics may be worked out. We do, of course, have an agreed upon mechanism for use in those instances when a Professional Standards Review Organization's performance does not improve despite our best efforts and when its failure to improve represents a serious financial concern for the state. To date, that mechanism has not been used but that is not to say that it may not be exercised in the future.

Specifically, the monitoring program has the following innovative and important features. The initial monitoring process consists of retrospective reviews of not more than 20% of all Medicaid discharges, conducted on quarterly schedules by a team of nurses and an administrator, with a physician ultimately responsible for the resulting determinations. The actual facilities selected in each Professional Standards Review Organization area for quarterly review are chosen based upon a statistically representative sample of hospitals with an appropriate variation in the proportion of Medicaid patients. Within the selected facility, the size of the sample of records scrutinized depends on the number of Medicaid claims paid for that given quarter. Random samples of claims are selected for retrospective review.

If there is a significant difference (95% confidence interval) between the number of Professional Standards Review Organization approved days and those the Office of Health Systems Management monitors would have approved, then the Office of Health Systems Management may initiate concurrent reviews for the next 90 days to validate its initial findings. If there is a significant difference during the concurrent reviews between the Professional Standards Review Organization and the state reviews indicating a continuing negative impact on state Medicaid expenditures (at least 95% statistical variation), then the state can recommend to the Department of Health and Human Services that it consider removing binding review authoritiy for Medicaid from the Professional Standards Review Organization. Finally, under the auspices of the New York Statewide Professional Standards Review Council, Inc., a three-member physician panel will review allegations by the state that a Professional Standards Review Organization has adversely affected state Medicaid expenditures. Only on a recommendation of this Council panel will Health and Human Services act to remove Professional Standards Review Organization authority over Medicaid review.

I believe that our presence in the utilization review process, as carried

out through our Monitoring Program, has been an asset to the Professional Standards Review Organizations across the state. The Professional Standards Review Organizations have a general level of performance that they have agreed to with the state, and to achieve that level they can use the specter of state intervention as a tool to motivate physicians and hospitals to utilize services in an appropriate and effective manner.

While our experience with the Monitoring Program has been positive, there is more, much more, to be done in making the current utilization review mechanism a viable cost-control tool.

It is very unfortunate for us, for Professional Standards Review Organizations, for physicians, for hospitals and for taxpayers that a short-sighted legal challenge was successfully brought in its initial court test against the second of the two programs which were agreed to by the Office of Health Systems Management and the Professional Standards Review Organizations with the full participation of the Department of Health and Human Services. It is equally unfortunate that the reversal by the United States Court of Appeals of the initial judicial decision in this matter took so long in being formalized and that the reimplementation of the program has been delayed.

The program of which I speak is the Demonstration Project designed to compare the performance of Professional Standards Review Organizations in a group of hospitals with that of the Office of Health Systems Management's on-site staff conducting reviews according to the same criteria in a second, matched group of hospitals. Performance of binding review by state staff in this latter group of hospitals was voluntarily agreed to by the Professional Standards Review Organizations through a formal delegation of authority back to the Office of Health Systems Management, and was approved by the Secretary of Health and Human Services.

The joint state-Professional Standards Review Organization Demonstration Project involved 53 hospitals in Manhattan, the Bronx, Brooklyn, Queens, and Erie County. It was agreed that the state and the Professional Standards Review Organizations would each review approximately 100,000 Medicaid discharges annually at participating hospitals for a two-year period. This two-year period would begin when a third-party evaluator was selected by the Department of Health and Human Services to assess the impact of the Office of Health Systems Management and Professional Standards Review Organization reviews on expenditures, utilization, quality of care, and administrative costs. The state

and Professional Standards Review Organizations began reviews on March 1, 1979 in anticipation of the selection of this evaluator.

On September 5, 1979 the United States District Court for the Eastern District of New York granted summary judgment enjoining New York State from continuing to operate the Demonstration Project. The suit, which was brought by the Greater New York Hospital Association, effectively prevented the objective comparison of differing utilization review mechanisms. Clearly, a study of the effectiveness of a decentralized, peer review, Professional Standards Review Organization-based utilization review program as compared to a centralized, standard review, state agency-based utilization review program would have been of great assistance to those policy makers in Washington who now must make a decision on the future of the Professional Standards Review Organizations without the advantage of comparative data.

It is my fervent hope that the delay caused by the Associations's misguided and ill-advised lawsuit does not end up seriously harming the effort to bring about effective utilization of hospital services; no short-term advantage to a handful of hospitals is worth the potential damage to the entire health care delivery system.

It should be evident from my remarks that I believe that an effective utilization review mechanism is an essential component of any viable health care cost control program. Beyond cost control, effective utilization review can bring about improvement in the quality of services rendered by reducing unnecessary institutional care, setting acceptable standards of care, and identifying sources of inappropriate care. It sets the stage for working toward elimination of such problems through education, developmental efforts, and legally empowered sanctions.

The Professional Standards Review Organizations have participated as full partners in such developmental efforts on a statewide basis. We are currently working with Professional Standards Review Organizations in developing acceptable standards of care in the treatment of alcoholism and alcohol abuse, which represents a massive and increasing public health concern in our society. The Professional Standards Review Organizations have joined with us in evaluating and further improving our current long-term-care patient assessment instrument, the DMS-1, as well as addressing the problem of hospital patients awaiting long-term-care placement. This latter effort will go beyond establishing standards for federal pay patients to the creation of industrywide standards applicable to all

patients regardless of source of payment. Clearly, this effort has the potential of fully and finally addressing an issue of major concern to all of us, the proper placement, planning, and treatment for those patients caught in an institutional netherworld in the midst of our health care system.

I firmly believe that the Professional Standards Review Organizations in their eight years of existence—at least in New York State—have become an important force in the effort to bring health care costs under control; they have also become an integral part of our effort to ensure the availability of quality health care services to all New Yorkers. Our relationship of rigorous but constructive criticism and professional cooperation has, I believe, had a positive impact on the health, both personal and financial, of the average citizen. Based on that belief, I wrote on March 9th to each member of the United States Senate Appropriations Committee—Subcommittee on Labor and Health and Human Services as well as our own Senators and members of the House Ways and Means Committee advising them of our support for continued funding for the Professional Standards Review Organization program in the state.

The Reagan administrations's budget initiatives in the area of health care regulation, particularly the elimination of funding for Professional Standards Review Organizations, makes neither substantive nor budgetary sense. Reliance on the hackneyed idea that marketplace forces should be put to work to bring about real health care cost control is simplistic and totally lacking in either an understanding of the health care delivery system or knowledge of the historical experience of that industry. Further, marketplace forces are not likely to provide any improvements in the equally important area of quality assurance and patient protection.

We in New York know better. We have been down that philosophical road before, and the toll extracted from us in regaining our financial health was far too great. Despite the final actions taken by either the administration or Congress on funding for Professional Standards Review Organizations, the Health Department has a legal obligation, based on unequivocal experience, to continue to review the utilization of health care services. That is an obligation that we cannot and will not back away from. The specific mechanics that we would use to reimplement a utilization review program should Professional Standards Review Organizations not be funded by the federal government is, at this point, only speculative. We would, of course, consider redeployment of our on-site program, utiliz-

ing the Professional Standards Review Organizations or a combination of both approaches. We have not spent much time or effort on alternative mechanics other than initial budget estimates; we prefer to focus our attention on reimplementing the Demonstration Project and monitoring current Professional Standards Review Organization performance.

Continuing effective utilization review is essential for the state's fiscal and physical health. At this point, I believe that continued operation of Professional Standards Review Organizations and the continued development of our constructively critical relationship is in the best interest of the people of New York.